Medicare coverage is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.

(7) If the QIO does not receive the information needed to sustain a provider's decision to terminate services, it may make its determination based on the evidence at hand, or it may defer a decision until it receives the necessary information. If this delay results in extended Medicare coverage of an individual's provider services, the provider may be held financially liable for these services, as determined by the QIO.

(8) The QIO's initial notification may be by telephone, followed by a written notice including the following information:

(i) The rationale for the determination;

(ii) An explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for the services; and

(iii) Information about the beneficiary's right to a reconsideration of the QIO's determination, including how to request a reconsideration and the time period for doing so.

(f) *Responsibilities of providers.* (1) When a QIO notifies a provider that a beneficiary has requested an expedited determination, the provider must send a detailed notice to the beneficiary by close of business of the day of the QIO's notification. The detailed termination notice must include the following information:

(i) A specific and detailed explanation why services are either no longer reasonable and necessary or are no longer covered;

(ii) A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy;

(iii) Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case; and

(iv) Any other information required by CMS.

(2) Upon notification by the QIO of the request for an expedited determination, the provider must supply all information that the QIO needs to make its expedited determination, including a copy of the notices required under § 405.1200(b) and under paragraph (f)(1) of this section. The provider must furnish this information as soon as possible, but no later than by close of business of the day the QIO notifies the provider of the request for an expedited determination. At the discretion of the QIO, the provider may make the information available by phone or in writing (with a written record of any information not transmitted initially in writing).

(3) At a beneficiary's request, the provider must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIO including records of any information provided by telephone. The provider may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The provider must accommodate such a request by no later than close of business of the first day after the material is requested.

(g) *Coverage during QIO review.* When a beneficiary requests an expedited determination in accordance with the procedures required by this section, the provider may not bill the beneficiary for any disputed services until the expedited determination process (and reconsideration process, if applicable) has been completed.

§ 405.1204 Expedited reconsiderations.

(a) *Beneficiary's right to an expedited reconsideration.* A beneficiary who is dissatisfied with a QIO's expedited determination may request an expedited reconsideration by the appropriate QIC.

(b) *Requesting an expedited reconsideration.* (1) A beneficiary who wishes to obtain an expedited reconsideration must submit a request for the reconsideration to the appropriate QIC, in writing or by telephone, by no later than noon of the calendar day following initial notification (whether by telephone

or in writing) receipt of the QIO's determination. If the QIC is unable to accept the beneficiary's request, the beneficiary must submit the request by noon of the next day the QIC is available to accept a request.

(2) The beneficiary, or his or her representative, must be available to answer questions or supply information that the QIC may request to conduct its reconsideration.

(3) The beneficiary may, but is not required to, submit evidence to be considered by a QIC in making its decision.

(4) A beneficiary who does not file a timely request for an expedited QIC reconsideration subsequently may request a reconsideration under the standard claims appeal process, but the coverage protections described in paragraph (f) of this section would not extend through this reconsideration, nor would the timeframes or the escalation process described in paragraphs (c)(3) and (c)(5) of this section, respectively.

(c) *Procedures the QIC must follow.* (1) On the day the QIC receives the request for an expedited determination under paragraph (b) of this section, the QIC must immediately notify the QIO that made the expedited determination and the provider of services of the request for an expedited reconsideration.

(2) The QIC must offer the beneficiary and the provider an opportunity to provide further information.

(3) Unless the beneficiary requests an extension in accordance with paragraph (c)(6) of this section, no later than 72 hours after receipt of the request for an expedited reconsideration, and any medical or other records needed for such reconsideration, the QIC must notify the QIO, the beneficiary, the beneficiary's physician, and the provider of services, of its decision on the reconsideration request.

(4) The QIC's initial notification may be done by telephone, followed by a written notice including:

(i) The rationale for the reconsideration decision;

(ii) An explanation of the Medicare payment consequences of the determination and the beneficiary's date of liability; and

(iii) Information about the beneficiary's right to appeal the QIC's reconsideration decision to an ALJ, including how to request an appeal and the time period for doing so.

(5) Unless the beneficiary requests an extension in accordance with paragraph (c)(6) of this section, if the QIC does not issue a decision within 72 hours of receipt of the request, the QIC must notify the beneficiary of his or her right to have the case escalated to the ALJ hearing level if the amount remaining in controversy after the QIO determination is $100 or more.

(6) A beneficiary requesting an expedited reconsideration under this section may request (either in writing or orally) that the QIC grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines in paragraph (c)(3) of this section do not apply.

(d) *Responsibilities of the QIO.* (1) When a QIC notifies a QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the QIC needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the QIC notifies the QIO of the request for an expedited reconsideration.

(2) At a beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIC. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

(e) *Responsibilities of the provider.* A provider may, but is not required to, submit evidence to be considered by a QIC in making its decision. If a provider fails to comply with a QIC's request for additional information beyond that furnished to the QIO for purposes of the expedited determination, the QIC makes its reconsideration decision based on the information available.

(f) *Coverage during QIC reconsideration process.* When a beneficiary requests an expedited reconsideration in accordance with the deadline specified in (b)(1) of this section, the provider may

not bill the beneficiary for any disputed services until the QIC makes its determination.

§ 405.1206 Expedited determinations for inpatient hospital discharges.

(a) *Beneficiary's right to an expedited determination for an inpatient hospital discharge.* A beneficiary who has received a notice of noncoverage under section 1154(e)(1) of the Act and 42 CFR 412.42(c)(3) may request an expedited determination by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary. A beneficiary who timely requests an expedited QIO review in accordance with paragraph (d)(1) of this section and who meets the conditions of section 1879(a)(2) of the Social Security Act (that is, the individual did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under part A or part B) may remain in the hospital with no additional financial liability until the QIO makes its determination.

(b) *When delivery of the notice is valid.* (1) Except as provided in paragraph (b)(2) of this section, valid delivery of the notice of non-coverage requires that the beneficiary (or the beneficiary's authorized representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents.

(2) If a beneficiary refuses to sign the notice, the provider may annotate its notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

(c) *Beneficiary's right to other review.* (1) A beneficiary who fails to request an expedited determination in accordance with paragraph (d)(1) of this section, and remains in the hospital, may request an expedited review at any time during the course of his or her inpatient hospital stay. The QIO will issue a decision in accordance with paragraph (e)(5)(ii) of this section. The escalation procedures described in § 405.1204(c)(5) and the financial liability rules of paragraph (f)(2) of this section do not apply.

(2) A beneficiary who fails to request an expedited determination in accordance with paragraph (d)(1) of this section, and who is no longer an inpatient in the hospital, may request QIO review within 30 calendar days after receipt of the notice of noncoverage as provided under section 1154(e)(1) or at any time for good cause. The QIO will issue a decision in accordance with paragraph (e)(5)(iii) of this section. The escalation procedures described in § 405.1204(c)(5) and the financial liability rules of paragraph (f)(2) of this section do not apply.

(d) *Procedures the beneficiary must follow.* For the expedited appeal process, the following rules apply:

(1) The beneficiary must submit the request for an expedited determination—

(i) To the QIO that has an agreement with the hospital under part 475 of this chapter;

(ii) In writing or by telephone; and

(iii) By noon of the first working day after he or she receives written notice that the hospital has determined that the hospital stay is no longer necessary.

(2) The beneficiary (or his or her authorized representative), upon request by the QIO, must be prepared to discuss the case with the QIO.

(e) *Procedures the QIO must follow.* On the date that the QIO receives the beneficiary's request:

(1) The QIO must notify the hospital that the beneficiary has filed a request for immediate review.

(2) The hospital must supply any information, including medical records, that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day after the day the beneficiary receives notice of the planned discharge.

(3) The QIO must examine the pertinent records pertaining to the services.

(4) The QIO must solicit the views of the beneficiary (or the beneficiary's authorized representative) who requested the expedited determination.

(5)(i) When the beneficiary requests an expedited determination in accordance with paragraph (d)(1) of this section, the QIO must make a determination and notify the beneficiary, the